Adopt He-M 305, previously effective 4-3-08 (Document #9120), and expired 4-3-16, to read as follows:

PART He-M 305 PERSONAL SAFETY EMERGENCIES

Statutory Authority: RSA 135-C:57, V; RSA 135-C:61 XI, XII

He-M 305.01 Purpose. The purpose of these rules is to define the circumstances in which, and mechanisms by which, involuntary emergency treatment, seclusion, or restraint can be provided in facilities serving individuals with mental illness. These emergency interventions are designed to be effective, safe, and time-limited and utilized only after all less restrictive options have been exhausted.

He-M 305.02 Definitions.

(a) "CMS regional office" means the office of the U.S. Department of Health and Human Services, Branch Chief, Survey and Enforcement Branch, Centers for Medicare & Medicaid Services, Room 2275, John F. Kennedy Federal Building, Boston, Massachusetts 02203.

(b) "Department" means the department of health and human services.

(c) "Facility" means New Hampshire hospital, Glencliff home for the elderly, or any other treatment program designated under RSA 135-C:26.

(d) "Individual" means a person receiving services from a facility.

(e) "Informed decision" means a choice made voluntarily by an individual or applicant for services or, where appropriate, such person's legal guardian, after all relevant information necessary to making the choice has been provided, when:

(1) The person understands that he or she is free to choose or refuse any available alternative;

(2) The person clearly indicates or expresses his or her choice; and

(3) The choice is free from all coercion.

(f) "Nursing staff" means a registered or licensed practical nurse or other care provider working under the direct supervision of a registered nurse.

(g) "Personal safety emergency" means a physical status or a mental status and an act or pattern of behavior of an individual which, if not treated immediately, will result in serious physical harm to the individual or others.

(h) "Physician" means a medical doctor licensed in the state of New Hampshire who is employed by, consultant to, or otherwise under contract with a facility.

(i) "Seclusion" means the involuntary confinement of an individual who:

(1) Is placed alone in a room or area from which the individual is physically prevented, by lock or person, from leaving; and

(2) Cannot or will not make an informed decision to agree to such confinement.

(j) "Restraint" means:

(1) Any drug or medication when it:

a. Is used as a restriction to manage an individual's behavior or restrict the individual's freedom of movement; and

b. Is not a standard treatment or dosage for the individual's condition, in that its overall effect reduces an individual's ability to effectively or appropriately interact; or

(2) Any manual method, physical or mechanical device, material or equipment that immobilizes an individual or reduces the ability of an individual to move his or her arms, legs, head, or other body parts freely but does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of an individual, if necessary, for the purpose of:

a. Conducting routine physical examinations or tests;

b. Protecting the individual from falling out of bed; or

c. Permitting the individual to participate in activities without the risk of physical harm.

(k) "Treatment" means medical or psychiatric care, excluding seclusion or restraint, provided by a physician, or a person acting under the direction of a physician, in accordance with generally accepted clinical and professional standards.

(l) "Training" means provision of education to staff, based on the specific needs of the individual population, resulting in demonstrated knowledge and documented competency.

He-M 305.03 Emergency Response.

(a) As soon as possible after an admission, the treatment staff of the facility and the individual shall develop a crisis plan to:

(1) Identify the individual's preferred response to a psychiatric emergency situation in order to avoid more restrictive interventions;

(2) Identify the individual's history of physical, sexual, or emotional trauma, if any; and

(3) Minimize the possibility of involuntary emergency measures.

(b) Involuntary emergency treatment, seclusion, or restraint in a facility shall not be implemented unless a physician determines that a personal safety emergency exists.

(c) A physician shall authorize involuntary emergency treatment, seclusion or restraint without consent of the individual or his or her guardian only following personal examination or observation, except as provided in He-M 305.04 or He-M 305.05 (b).

(d) No involuntary emergency treatment shall be administered pursuant to He-M 305 unless it is to take effect within 24 hours and is expected to alleviate or ameliorate the status or condition which has caused the emergency.

(e) The emergency response that is administered pursuant to He-M 305 shall be an intervention that:

(1) Is expected to be effective;

(2) Considers whether any of the following factors regarding the individual's condition would require special accommodation to ensure necessary communication and the individual's safety:

a. Medical factors;

b. Psychological factors; and

c. Physical factors, including:

1. Blindness or other limitations of sight;

2. Deafness or other limitations of hearing; and

3. Any other physical limitation that would require special accommodation;

(3) Is the least restrictive of the individual's freedom of movement; and

(4) Gives consideration to the individual's preferred response to a psychiatric emergency situation.

(f) Involuntary emergency treatment, seclusion, or restraint ordered following a personal safety emergency shall be authorized for no more than is necessary, but in no case for more than 24 hours in accordance with He-M 305.04(k).

He-M 305.04 Seclusion or Restraint.

(a) An emergency response may include restraint or seclusion.

(b) Restraint or seclusion shall:

(1) Not be imposed longer than is necessary to resolve a personal safety emergency regardless of the length of the time identified in the order; and

(2) Not exceed 30 minutes unless there is documented authorization by a physician.

(c) Before seclusion or restraint is employed, an individual who can make an informed decision to be voluntarily placed in an unlocked room shall be offered that alternative, if feasible.

(d) Restraint or seclusion shall be used only as a last resort when no other intervention in an emergency situation is feasible to protect the immediate safety of the individual or others.

(e) Seclusion or restraint shall never be used explicitly or implicitly as punishment for the behavior of the individual.

(f) Individuals in seclusion or restraint shall be afforded privacy through practices including:

(1) The use of a single room;

(2) Minimizing external stimuli such as noise, nearby movement, and approaches by other individuals; and

(3) Continuous staff observation to assure the conditions in (2) above are met.

(g) Authorization for the use of seclusion or restraint shall be as follows:

(1) A physician may write an order for the use of seclusion or restraint; or

(2) A physician may authorize the use of seclusion or restraint via telephone when the order:

a. Follows deliberate and comprehensive consultation between the physician and a trained advanced registered nurse practitioner (ARNP) or registered nurse (RN) who has personally evaluated the individual by reviewing:

1. The assessments of the individual that have been performed;

2. The safety issues involved; and

3. The potential antecedents to the seclusion or restraint;

b. Is for a period not to exceed one hour; and

c. Is countersigned by the ordering physician within 24 hours of the time such treatment was ordered.

(h) A physician may authorize in writing, on the physician order sheet, or verbally, by telephone, the extension of an order of seclusion or restraint if he or she, or a trained ARNP or RN, has personally examined, observed, and assessed the individual for whom the seclusion or restraint is ordered.

(i) Following an examination and assessment as required by (g) above, a physician may issue an order to extend seclusion or restraint if the order is for:

(1) Not more than 4 hours if the individual is at least 18 years old;

(2) Not more than 2 hours if the individual is at least 9 but not more than 17 years old; or

(3) Not more than one hour if the individual is less than 9 years old.

(j) A physician who authorizes seclusion or restraint shall, in collaboration with the attending registered nurse, establish release criteria for the termination of the seclusion or restraint.

(k) If the condition of the individual does not improve to meet the criteria for termination, the physician may renew the order as specified in (h) above for up to the time limits established in (i) above,

provided that no individual shall remain in seclusion or restraint for more than 24 hours from the time such procedure was initiated unless a physician personally examines, observes and assesses the individual and renews the order in writing.

(l) Nursing staff trained pursuant to He-M 305.07 shall continually monitor the individual during periods of seclusion or restraint to ensure that:

(1) In the judgment of the nursing staff, all reasonable measures are in place to ensure that the individual's health and safety is protected during the period of seclusion or restraint;

(2) The individual receives meals and regular opportunities to move and to utilize the bathroom;

(3) All other basic physiological needs are identified and met; and

(4) The seclusion or restraint is discontinued as soon as the emergency is resolved, regardless of the length of time identified in the order.

(m) Individuals in seclusion or restraint shall have the right to:

(1) Wear their own clothes, unless clinically contraindicated; and

(2) Meet with an attorney.

(n) No procedure or device for seclusion or restraint shall be utilized without the authorization of the clinical managers of the facility.

He-M 305.05 Emergency Medication and Other Emergency Treatment.

(a) A physician in a facility shall prescribe medication as a form of emergency treatment, to be administered without the individual's consent, only after personally examining or observing the individual for whom the medication is ordered, except as provided in (b) below.

(b) A physician may authorize involuntary administration of a previously prescribed medication by telephone order at the time a personal safety emergency is declared. Such authorization shall be countersigned by the ordering physician within 24 hours of the order for involuntary administration of the medication.

(c) When emergency medication is ordered, the individual shall be offered, whenever feasible, a choice of taking the medication orally or by injection.

(d) Psychosurgery, electroconvulsive therapy, sterilization, or experimental treatment of any kind shall not be used as involuntary emergency treatment.

He-M 305.06 Review and Documentation of Emergency Response.

(a) At the time that any emergency treatment, seclusion, or restraint is administered in a facility pursuant to He-M 305, the physician administering or directing such treatment, or a person acting under his or her direction, shall promptly record the circumstances pertaining to the personal safety emergency.

(b) The person completing a record pursuant to (a) above shall include the following:

(1) The individual's name;

(2) The date and time when the report is completed;

(3) The physician's name;

(4) A description of the individual's physical or mental status and the act or pattern of behavior which constitutes the emergency;

(5) The names of any witnesses other than the individual;

(6) A description of any alternatives attempted or considered prior to declaring a personal safety emergency;

(7) Any treatment limitations;

(8) A description of the specific emergency treatment, seclusion, or restraint ordered; and

(9) The physician's signature.

(c) As soon as possible following an involuntary emergency treatment, seclusion, or restraint, facility medical or nursing staff, or both shall advise the individual's treating physician regarding the emergency intervention if such intervention was not ordered by the treating physician.

(d) As soon as possible following the resolution of the emergency situation, nursing staff shall:

(1) Address any physical injuries or trauma that might have occurred as a result of the episode;

(2) Hold and document a discussion with the individual to:

a. Review the circumstances that led up to the emergency with the individual involved;

b. Ascertain the individual's willingness or desire to involve family or other caregivers in a debriefing to discuss and clarify their perceptions about the episode and to identify additional alternatives or treatment plan modifications;

c. Hear and document the individual's perspective on the episode;

d. Discuss and clarify any possible misperceptions the individual or staff might have concerning the incident;

e. Identify with the individual any environmental changes or alternative interventions to reduce the potential for additional episodes; and

f. Ascertain whether the individual's rights and physical well-being were addressed during the episode and advise the individual of the process to address perceived rights grievances; and

(3) Support the individual's re-entry into the treatment setting.

(e) Within one business day, nursing staff shall, after discussion with the individual, modify the treatment plan as needed through a treatment team review including areas noted in (d)(1)-(3) above and seek an informed decision on that plan by the individual; and

(f) An executive review of the clinical appropriateness of the use of seclusion or restraint shall be conducted:

(1) As authorized by the facility's chief executive officer;

(2) On the next business day following a personal safety emergency;

(3) To assess compliance with the requirements of He-M 305;

(4) To consider and take any action needed to prevent the recurrence of the same or similar personal safety emergencies; and

(5) To include:

a. A member of the individual's treatment team;

b. A member of nursing management; and

c. The medical director or designee.

He-M 305.07 Training.

(a) Facilities shall provide training for leadership in strategies toward the elimination of seclusion and restraint.

(b) At a minimum, facilities shall provide training at the following intervals to all staff who will be involved in the use of any type of restraint or seclusion:

(1) During initial orientation; and

(2) During annual competency evaluation.

(c) Staff shall not perform any action relative to restraint or seclusion without having been trained in the use of such methods, in accordance with (d) below.

(d) Training in the use of restraint or seclusion shall address at least the following:

(1) Techniques to identify behaviors, events, and environmental factors regarding individuals and staff that might trigger circumstances that require restraint or seclusion;

(2) Use of non-physical interventions;

(3) How to identify and choose positive behavioral supports and the least restrictive intervention based on an individualized assessment of the individual's medical or behavioral status or condition;

(4) How to ensure that the individual and staff are able to communicate effectively;

(5) Safe application and use of all types of restraint or seclusion, including mitigating positional risks that can result in asphyxia or airway obstruction, in accordance with individual needs;

(6) How to monitor the physical and psychological well-being of the individual who is restrained or secluded;

(7) How to recognize and respond to signs of physical and psychological distress;

(8) How to identify clinical changes that indicate that restraint or seclusion is no longer necessary;

(9) How to monitor respiratory and circulatory status, skin integrity, and vital signs during restraint; and

(10) Training in first aid techniques and certification in cardiopulmonary resuscitation (CPR), including CPR recertification every two years.

(e) Training shall be given by a person who:

(1) As defined in writing by the facility, possesses the requisite qualifications based upon education, training, experience and certification to teach the assessment of, and response to, an individual's medical or behavioral status or condition;

(2) Is certified by a nationally recognized program, such as the American Heart Association, as an instructor in CPR; and

(3) Is trained in crisis prevention utilizing a nationally recognized program or comparable curriculum.

He-M 305.08 Notice and Right of Appeal.

(a) On the business day following administration of emergency treatment, seclusion, or restraint under He-M 305, the individual's case manager or another staff member designated by the program or facility shall forward the following to the individual or his or her guardian:

(1) A copy of the record completed pursuant to He-M 305.06(a);

(2) The specific rules that support, or the federal or state law that requires, the action;

(3) Notice of the individual's right to complain against and appeal the administration of emergency treatment as a client rights violation in accordance with the emergency procedures contained in He-M 204 and He-C 200, rules of practice and procedure;

(4) Notice of the right to have representation in an appeal by:

a. Legal counsel;

b. A relative;

c. A friend; or

d. Another spokesperson;

(5) Notice that neither the facility nor the bureau is responsible for the cost of representation; and

(6) Notice of organizations with their addresses and phone numbers that might be available to provide legal assistance and advocacy, including the Disabilities Rights Center and pro bono or reduced fee assistance.

(b) Appeals of the final decision under He-M 204 shall be forwarded, in writing, to the director of the bureau of behavioral health in care of the department's office of client and legal services. An exception shall be that appeals may be filed verbally if the individual is unable to convey the appeal in writing.

(c) The director shall immediately forward the appeal to the department's administrative appeals unit for action in accordance with He-C 200. The burden shall be as provided by He-C 204.14. A proposed decision shall be issued in accordance with He-M 204.

He-M 305.09 Reporting of Death.

(a) In accordance with Patient Rights 42 CFR 482.13(f)(7) and the Protection and Advocacy for Mentally Ill Individuals Act (PAIMI Act), 42 U.S.C. § 290, facility staff shall make a telephone report to the CMS regional office, no later than the close of the next business day and to the state protection and advocacy agency within 7 days following knowledge of an individual's death that:

(1) Occurs while an individual is in restraint or in seclusion at the facility;

(2) Occurs within 24 hours after the individual has been removed from restraint or seclusion; and

(3) Occurs within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to the individual's death including, at a minimum:

a. Death related to restrictions of movement for prolonged periods of time; and

b. Death related to chest compression, restriction of breathing, or asphyxiation.

(b) Staff shall document in the individual's medical record the date and time the death was reported.

APPENDIX

RULE	STATUTE
He-M 305.01-305.02	RSA 135-C:57, IV, RSA 126-U:1
He-M 305.03(a)	RSA 135:21-b, RSA 126-U:3
He-M 305.03(b)	42 CFR 482.13(e)(3)(ii); (f)(3)(ii)

He-M 305.03(b)-(d)	RSA 135-C:57, IV
He-M 305.03(d)	42 CFR 482.13(e)(2), (3)(ii)(A); (f)(2), (3)(ii)(A)
He-M 305.03(e)(2)	42 CFR 482.13(e)(3)(iv); (f)(3)(iv)
He-M 305.03(e)-(f)	RSA 135:21-b
He-M 305.04(a)	RSA 135-C:57, V, RSA 126-U:4, :5, :5-a, :5-b, and :11
He-M 305.04(b)(1)	42 CFR 482.13(e)(3)(vi); (f)(3)(vi)
He-M 305.04(b)-(d)	RSA 135:21-b
He-M 305.04(c), (d)	42 CFR 482.13(e)(3)(i); (f)(3)(i), RSA 126-U:4, :5, :5-a, :5-b
He-M 305.04(e)-(i)	RSA 135-C:57, IV, RSA 126-U:4, 5, :5-a, :5-b
He-M 305.04(f)	42 CFR 482.13(c)(1), RSA 126:5 and :5-a
He-M 305.04(g)	42 CFR 482.13(e)(3); (f)(3), RSA 126-U:2 and :11
He-M 305.04(h)	42 CFR 482.13(e)(8)
He-M 305.04(i), (k)	42 CFR 482.13(f)(3)(ii)(D)
He-M 305.04(j)	RSA 135-C:61, XI
He-M 305.04(k)-(l)	RSA 135-C:57, IV
He-M 305.04(l)	42 CFR 482.13(f)(4)
He-M 305.04(l)(4)	42 CFR 482.13(f)(3)(vi)
He-M 305.04(m)	RSA 135:21-b
He-M 305.05(a)-(b)	RSA 135-C:57, IV 42 CFR 482.13(e)(3)(ii); (f)(3)(ii), RSA 126-U:1
He-M 305.05(c)-(d)	RSA 135:21-b
He-M 305.06(a)-(b)	RSA 135-C:57, I, RSA 126-U:7 and :10
He-M 305.06(c)	RSA 135-C:61, XI 42 CFR 482.13(e)(3)(ii)(B); (f)(3)(ii)(B), RSA 126-U:7 and :10
He-M 305.06(d)-(f)	RSA 135-C:61, XII, RSA 126-U:7 and :10
He-M 305.07	RSA 135-C:5, (b)
He-M 305.07(a)	42 CFR 482.13(e)(5); (f)(6)
He-M 305.08	RSA 135-C:61, XII
He-M 305.09	42 CFR 482.13(f)(7), RSA 126-U: 7 and :10